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ABSTRACT

This transcript is the result of panel presentation given on the implications of liberalized abortion laws for counselors. A new law which went into effect in July, 1970, in New York State presented women with the option of obtaining a legal abortion up to the 24th week of pregnancy. Counselors in New York State were, therefore, presented with new alternatives in dealing with women with unwanted pregnancies. The panel included a gynecologist discussing the impact of the law on the state and a college community; a Newman chaplain reflecting on alternatives to abortion; two counseling psychologists discussing personal reactions to the abortion issue and its impact on a college population; and a black counselor comparing the reaction of whites and nonwhites to unwanted pregnancies. The problem of unwanted pregnancy presents serious dilemmas to counselors. This panel presentation was an attempt to incorporate a wide range of viewpoints on this issue. (Author/WS)

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ABORTION, BIRTHRIGHT AND THE COUNSELOR

AN OVERVIEW

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THE PERSPECTIVE OF A FEMALE COUNSELOR

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THE PERSPECTIVE OF A PHYSICIAN

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THE PERSPECTIVE OF A COUNSELING CENTER DIRECTOR

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THE PERSPECTIVE OF A BLACK COUNSELOR

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THE PERSPECTIVE OF A CATHOLIC PRIEST

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AN OVERVIEW

Abortion and the problem of unwanted pregnancy involves many complex questions of morality, medicine, theology and law. Answers differ widely. A segment of the medical profession considers abortion to be primarily a medical problem and feels constrained by laws which have little relation to the best interest of their patients. Organized religions take differing positions, and their spokesmen often disagree on basic concepts, such as when does life begin. What to do about an unwanted pregnancy remains an emotionally explosive subject.

The lack of public consensus of this issue is reflected in national opinion. For example, a survey by the Association for the Study of Abortion has shown that abortion to preserve the mother's health or to prevent child deformity is well accepted, whereas abortions for discretionary reasons receive minimal, but nevertheless, some growing support. A March 1972 public opinion poll taken for the United States Commission on Population Growth reported that six out of ten American adults favored abortions for reasons other than saving the mother's life. Fifty per cent of the adults favored legalizing abortion for women who want it.

Abortion is not new but an ancient practice. In the United States it was not until 1821 that the first law prohibiting abortion was enacted in the state of Connecticut. Other states followed with similar laws, usually with the exemption "when necessary to save the life of the mother." These laws remained relatively unchanged until recently.

The current legal status of abortion within the United States has been categorized by Duffy (1971) into three levels of restrictions: the more restrictive, the less restrictive, and the least restrictive. The more restrictive laws allow abortion only to protect the life of the mother. This type of legislation is found in approximately 33 states. Enactment dates of these laws extend as far back as 1835 in Missouri and as recent as 1943 in North Dakota. In 1967 Colorado was first among

approximately 17 states that liberalized their abortion laws. This less restrictive category includes 11 states that, like Colorado, adopted or modeled the American Law Institute's Code. The code recommends allowing an abortion up to 16 weeks when a medical board agrees that the health of the woman is in danger, that the fetus may be abnormal, or in cases of rape or incest.

The least restrictive category includes four states: Alaska, Washington, Hawaii and New York. They have no legal restrictions on reasons for abortions. The most liberal or permissive of all states is New York. It has removed the provision of residency. Every woman resident or visitor has a legal right to an abortion up to the 24th week of pregnancy. New York requires only that a physician perform the abortion. The patient and her doctor's decision is all that is needed. No consent of parent or husband is required if the patient is 17 years or older.

You may ask the question: "What has happened in New York State since the law went into effect?" The New York State Department of Health reports that approximately 215,453 induced abortions were performed in New York State since the laws inception (July 1, 1970 through June 30, 1971). Fifty-four per cent of the abortions were performed on non-residents. Sixty-one per cent of the abortion patients were under 25 years of age. The maternal death rate from induced abortions was 6.5 per hundred thousand; well below the 19 per hundred thousand live births and fetal deaths.

Since New York State has legalized abortion, doctors and other professionals across the United States and Canada report that as a result of available legal alternatives, fewer patients seek treatment after illegal abortions and that patients seek abortions earlier in their pregnancies. This survey by Wickersham Medical Center further indicates that abortion patients benefit from consultation with professional counselors.

Experience with legalization is new and limited. Empirical knowledge is minimal,

thus both attitude and practice are often determined by personal bias or beliefs rather than professionally verified knowledge or principles of practice.

Our purpose here today is not to offer solutions or formulate conclusions concerning the abortion-birthright issue, rather we wish to share with you our experiences with the liberal abortion law and our experiences with the emerging Birthright Program. The title of our presentation reflects our concern---namely the counselor in the midst of the abortion-birthright alternative.

At professional meetings it appeared to us that the new trends were not being dealt with and the counselor needed to encounter the issues. Therefore, we hope our presentation may be of assistance to the growing number of counselors who will be exposed to the liberalizing trend in abortion laws and the growth of alternative programs to abortion.

Our presenters reflects the major professions concerned with the issue of unwanted pregnancies. I will introduce them in the order of presentation.

Miss Dianne Beeman, a college counselor, will present some of the issues that a female counselor encounters.

Dr. Theodore Jacobus, Obstetrician and Gynecologist and Director of a newly instituted Family Planning Center, will discuss the medical aspects of abortion. He has dealt with contraception and abortion in a college community.

Dr. Anthony S. Papalia, Director of a College Counseling Center, will discuss the position of a counselor in working with women experiencing unwanted pregnancy, with specific reference to conditions prior to and after legalized abortion.

Mr. Robert Knight, a college counselor, who devotes a portion of his time to minority group counseling, will speak on the abortion and birth control issue as it applies to the minority groups.

Father Edward O'Heron, Newman Chaplain, will discuss something of the moral

dimensions related to abortion and the abortion alternative programs, such as Birthright.

THE PERSPECTIVE OF A FEMALE COUNSELOR

On March 28, 1970 a rally was held in New York City of women who wanted New York State's antiquated abortion law repealed. One agitator carried a sign which read, "Thanks Mom, you didn't flush me down the toilet." Five days later when the New York State Legislature voted to amend the abortion law, the impact was overwhelming and widely divergent views resulted. There were emotionally charged reactions as many people's religious and moral views were affronted. There were a great number of requests for physicians' time and hospital or clinic space. Business boomed as new facilities, travel plans, and referral services were established to accommodate women desiring to terminate unwanted pregnancies. These were but a few of the many reactions.

What effect did this upsurge of activity have on those of us in the counseling profession, who by nature, are trained to avoid being judgmental and advocating one particular point of view? I think that before we can even begin to talk about the process of counseling with young women about the issue of an unwanted pregnancy, we must first take the time to prepare ourselves. I would suggest that it is very difficult to counsel someone effectively in this area if you have not dealt with your own feelings and attitudes, and any basis you might have as a result of experience, or religious or moral convictions. This will not be an easy process as we found in preparing this presentation, and hopefully your position is flexible enough to incorporate new ideas; but the fact remains that a basic understanding of your own views is important.

Secondly, as a component of self-preparation, I would emphasize the importance of being well informed. This hopefully applies in any counseling situation, but

seems particularly relevant in such a concrete situation as pregnancy. In order to offer alternatives, the counselor must be familiar with agencies or clinics and the services they provide, programs such as Birthright which Father O'Heron will discuss, names of gynecologists, and other referral sources in his or her particular area. Some knowledge of the fees that are charged and perhaps some indication of attitudes or specific approaches to the individual might be useful also, and I will say more about this later.

I would now like to discuss some of the most common issues that we have observed with respect to counseling and the question of abortion at the college level. The first issue is sometimes establishing the certainity of pregnancy. We will occasionally see girls who are frantically grasping for alternatives when their suspicions have not yet been confirmed. If the girl is sure she is pregnant, the counselor must deal with whatever immediate, emotional reaction may be present. This is an example of a point at which the counselor's attitude may be extremely important. As Leah Potts (1971) explains in her article on counseling women with unwanted pregnancies in the book, Family Planning: Readings and Case Materials, an unwanted pregnancy need not be a crisis in and of itself, and the degree to which the counselor views it as a traumatic experience may affect the girl's feelings about herself.

Another issue which may arise is the sex of the counselor. At the college level most girls are not uncomfortable with a male counselor, while others will request to talk with a female.

A third issue, which rarely occurs for us but may arise for some of you, is your ethical obligation in dealing with a girl who is under age. In New York State facilities this is 17. This girl may need parental consent for a pregnancy test, and almost certainly will need it for an abortion if that happens to be her decision. The question of whether or not, or how to inform the girl's parents, must be decided

by the counselor and the client. This leads directly to the issue of whether or not the girl plans to include anyone else in her decision-making process, such as her parents, the father of the baby, clergymen or other important people in her life. In dealing with this entire issue, we must remember that our code of ethics charges us with a primary obligation to our client, even though we operate on the basic belief in the worth and dignity of all human life. So if you happen to be leaning toward affiliation with a group such as Friends of the Fetus or Voice of the Unborn, and you are also involved in counseling, you may have some conflicting feelings which will need to be resolved. If you feel strongly against abortion, you may feel the necessity to be honest with your client and proceed from there.

Another important area for consideration is that of interpersonal relationships, particularly with the father of the baby or other males, and the girl's attitudes about sex, contraception, and the possibility of future pregnancy or lack of it, since part of the fear of abortion is sometimes the possibility of difficulty having a baby if and when it is desired. The next step will be the exploration of the various alternatives which are feasible and their meaning to the particular woman involved, and then reaching a final decision. Hopefully, counseling will continue after the choice is executed.

As you have probably noticed, there is very little difference in terms of process between counseling in this area and counseling with any other type of problem. Your effectiveness will depend more on the quality of the relationship which you establish with your client than on any technique you use or alternative you offer. If the girl has chosen abortion as the best alternative for her, the counselor may then want to spend some time discussing with the girl some of the things which she might experience. One of the recurrent reports in the accounts which I have read and heard about is the rather negative attitudes and inhuman treatment by medical

personnel toward women undergoing abortions. For whatever reasons, and there are some obvious and justifiable ones, this treatment can be detrimental to the girl's emotional health and her feelings of self-worth and may contribute more to feelings of guilt than the actual abortion.

A recent study by Hall (1971) and another by Fleck (1970), both physicians, discuss the need for improved attitudes among staff members of many facilities which perform abortions since they still seem to be finding ways to discourage women from obtaining abortions, by setting age limits or charging exorbitant fees.

Another effect which some women, particularly married ones, may experience is the postpartum depression (which also occurs after childbirth) although this may be counteracted by the immediate sense of relief which the woman is likely to feel if the abortion was totally voluntary. One of my real concerns is the little attention which has been given to the possibility of future negative psychological effects as a result of an abortion. It is still too early for any conclusive evidence and there is an obvious need for follow-up research. I have been talking about a counseling process which assumes that young women will seek counseling before they make a decision, and this is often not the case. College students, particularly, will often discuss the problem with friends who will help offer alternatives. Another concern which I think we as counselors in New York State feel is that abortion is rather easily accessible and the girl may only consider her immediate dilemma rather than considering all the effects which her action might imply.

Recognizing the fact that none of us can be totally objective, I would like to digress slightly to share with you some of my personal feelings about the issue of abortion and changes in the legislation. First, let me call your attention to the fact (and those of you who are particularly perceptive may have already noticed this) that I am the only female in a group of six people who are discussing a procedure

that can only be performed on a women's body. Notice I did not say that only women are affected by the process; and I am fairly certain that this ratio is not atypical of most legislative bodies to say nothing of hospital or clinic administrators or physicians. Any attempt at legislating morality or generalizing about the protection of all forms of human life completely denies the free choice of a woman to decide for herself what happens to her body. The majority of the state abortion laws, which are only recently starting to be liberalized, were enacted before women won the right to vote and to say won implies a lack of equality which seems to still exist. Efforts toward creating justice should be channeled toward repeal rather than reform. The action which was taken in New York State was the first change since 1828 in a state provision that a woman could be administered a legal abortion only if her life were in danger. It is rather shocking that 33 states still have this provision, while another 11 states, with slight variations, allow abortion only in the event of rape or incest, a predetermined physical deformity in the baby, or risk to the woman's physical or mental well-being. The fact that abortions have been illegal certainly does not mean that they have not been performed. In fact, complications from abortions have been the largest source of maternal death in our country. The restrictive laws force those women with unwanted pregnancies to resort to dangerous backroom abortions often performed by totally untrained people, and to travel and spend large sums of money which raises the issue of socioeconomic discrimination. Those states which require hospitalization, and even with New York's liberal law, the necessity of having a licensed physician perform the abortion, still make it impossible for many women to obtain a safe legal abortion. It would be quite feasible to train paraprofessionals in one abortion method to alleviate some of the discrimination which now exists. In many states a woman must convince a board that she is physically or mentally unhealthy. When a woman must try to convince a panel, con-

sisting of at least two psychiatrists and other medical personnel, that her mental health may be impaired if she is forced to bear a child against her will, she is being forced to act as unstable as possible. This seems to me like a direct contrast to the goal of improved mental health pursued by psychiatrists. Our society, which is so obsessed with feminine beauty and sex appeal, must learn to accept unmarried women with children and abortions upon request.

The decision to terminate a life is obviously not a pleasant thought, nor is the thought of thousands of unwanted children. The ideal situation would be prevention, rather than termination, of pregnancy. If I were faced with an unwanted pregnancy, the decision to have an abortion would be an extremely difficult one but I would be quite bitter if I knew I couldn't legally obtain an abortion, or if I had to travel a long distance to insure the safety of the procedure. To give up my freedom to decide about the destiny of something within my own body to particular physicians or psychiatrists, or the state, seems unjustifiable.

Before concluding, I would like to briefly return to counseling and some specific recommendations. Dealing with an unwanted pregnancy is a serious situation for any woman, but can be exceptionally difficult for a young girl who may be too frightened to tell anyone. I can't emphasize enough the need for improved sex education at the high school and junior high levels. Group discussions of sexuality and contraceptives might be useful for young people, as well as groups for parents to discuss ways of dealing with their children in this area. There is always the need for counselors to improve communication with their clients, so that if a young girl gets pregnant, she will feel free to discuss it with her counselor. Within the counseling relationship, the counselor has the responsibility to strive for objectivity but outside that relationship he also has a responsibility to work for those things in which he believes; and in any counseling relationship, there

is always the opportunity for developing more tolerant attitudes. Regardless of how knowledgeable you may become with respect to the issue of abortion, your viewpoint will be the result of a very personal feeling. We are not here to change those feelings, but if we encourage you to think about them, we will have accomplished our goal.

THE PERSPECTIVE OF A PHYSICIAN

You have heard from a counselor. You will hear from some more counselors. You will hear from the neighborhood priest, but now you are going to hear from the friendly, family abortionist. First of all, I must say that I feel that abortion is a viable alternative to pregnancy. As a matter of fact, in some instances, I feel that abortion is the only sensible alternative to pregnancy.

A little bit about the population and the statistics that I am going to use. Cortland, New York is unique in some ways in that there are only two physicians who do abortions in the county of Cortland. They happen to be one of my partners and myself. This gives us a captive audience as far as statistics go. Another interesting statistic is that there are only two places where pregnancy tests are done within Cortland County. They are done in our office and in the local hospital, where very few are done. Therefore, we have within our own office a very good cross-section of the abortions that are done in the county and also the pregnancy tests that are done within the county. Until recently, our office was the only place where a college girl could have contraceptive information. As was mentioned, Cortland has just opened a County Family Planning Clinic. Ninty-five per cent of the patients have been college students.

We do about 50 abortions per year on college students. We have about 2,500 female college students in Cortland, so this runs about two per cent. We do, however, better than one AZ a day on Cortland college students. This is over three

hundred a year at around 12 per cent, and I found it almost unbelievable that better than one out of ten college students per year would worry about being pregnant. My daughter has recently told me that my problem is being too rational, and I don't act usually before I think it out; and most people are not rational and as a result take chances which they shouldn't. I should explain that an AZ test is a pregnancy test. In our office when we do the pregnancy tests, we will do it on anybody that brings in a urine specimen. We do not require that it be their urine, and as long as they use the same name in the afternoon when they ask for the result, as the name they used in the morning, they will get a straight answer. We don't report any of our pregnancies to the college authorities.

The idea that the pill has been a cause of the change in sexuality, I think, is a very false premise; and I think that the change in sex and the attitudes toward sex and sexuality have been the main cause for the increase in pregnancies among the college population, and the high school population, and the junior high school population. When a girl comes into the office for an abortion, she has usually made up her mind before I see her. With the first few girls that we saw, I did try to do some counseling and I soon realized that these girls had made up their minds, and they viewed any attempt on my part to talk out their problem with them as a censure on the fact that they were going to have an abortion. So at this point, I terminated whatever counseling I was attempting to do, and just discussed the pregnancy and how we were going to abort it. I did some counseling after the abortion on contraception control.

You may be interested in knowing some of the problems that patients talk over with us. Of course, price is the first thing that they want to know, "How much is it going to cost?" Other questions we get include---"Will it interfere with future pregnancies?" "How much is it going to hurt?" Basically these are three of the

major questions that we do get before the abortion. Now when a girl is to have an abortion, she is given an instruction sheet and is told then of her appointment She is informed that she must sign and have witnessed a consent and release form. In our office any girl over 18 can have an abortion without parental consent, even though the actual age is 21 in New York State. I will not do an abortion on any girl without her consent. We have had a few instances recently where mothers, of a 15 year old girl and a 16 year old girl wanted them to have an abortion; and the girls didn't want it so I refused to do it. I explained I would rather do the abortion without the parent's consent than without the girl's consent. We warn them about eating or drinking after midnight, and we tell them how we are going to terminate the pregnancy; and that we will do it under a local anesthesia if they are under 10 or 11 weeks gestation. In other words, ten weeks from the onset of their last menstrual period. We do them in the office. We find that by doing them in the office there are less busy bodies involved and less old biddies who tend to look down upon the girl; and we find that we can do it very safely. We have exactly the same equipment in our office that we have in the hospital and we can cut out alot of red tape by doing it. We tell them that they will rest for about an hour after the abortion; that they should have somebody pick them up. We will not do an abortion unless we know the girl will have a companion to take her home, and we warn them about possible hemorrhage, temperature, and what to do for the next 24 hours. We have found that after 24 hours most girls are ready to return to full duty. As a matter of fact, one of the first questions we get following an abortion is: "When can I have intercourse?" I find this a little difficult to understand. Other questions that we get are: "When can I go back to school?" "When can I start taking the pill?" We usually recommend that most girls start taking the pill about a week following the abortion. We warn them not to have intercourse for four weeks hoping that they won't have intercourse for at least ten days, and by that time the

pill will have started to work. Interestingly enough we get more thanks from girls on whom I have done an abortion than on their mothers who I may have saved from cancer. It is not unusual for the girl to remind the nurse to please thank the doctor. I assure you we rarely get this after we have done a hysterectomy or some other procedure.

Here are some statistics you may find very interesting. One is that 32 per cent of the girls are Catholic, 56 per cent are Protestant and only 8 per cent are Jewish. Now, in our local college we have quite a large number of girls from New York City and its environment; and as best as I can figure out the Jewish population is about 25 per cent. The only thing that I can figure out is that either they have better sex information, because of more liberal background and use better contraception, or their parents being more liberal they feel they can go home with their abortion and not have it done locally. A number of abortions are done locally on girls from Long Island. Seventy-six per cent of our girls go on the pill. As a matter of fact, 85 per cent use some form of contraception. We have none who have used the I.U.D., the interuterine device, and this is a bias on the part of the obstetricians involved; because my partners and I just don't happen to like the interuterine device. Eight per cent apparently say they will never have sex again and we only lose about 10 per cent. We have about 90 per cent follow-up on our girls, which I think is very high. We see them all four or five weeks following the abortion, and at that time if they haven't taken the pill, or thought it over, we again suggest that they do something because we really don't want to see them back in the office again. We have noticed among other things that the stage of pregnancy is much earlier now than it was in the onset of the law. Among our students 48 per cent come in by the eighth week. In other words, most of them have barely missed a second menstrual period or have not missed a second menstrual period. We

try and encourage them to bring a urine specimen in within two weeks after the first missed menstrual period.

Pregnancy is one of the emergencies in our office. The easiest way to get an appointment in our office is to be pregnant and want an abortion. The only other way you can get an appointment immediately is to be either hemorrhaging or in such severe pain that you can hardly walk. If a girl phones to deposit pregnancy tests or she wants an abortion, she is scheduled for an appointment that week; and we usually abort them later that week or the following week.

The only group that reports an earlier percentage on early abortions are the women over 35, and about 60 per cent of them come by the eighth week. The question and the problem of depression following abortion is one that I have not seen very frequently, and I think that as our attitudes toward abortion change you will find much less of this. I think that this is attitudinal in that I know many doctors find it very difficult to adjust their attitudes to abortion. It is like the virgin who gets married and all of a sudden is suppose to be a completely sexual person whereas up until then, she has been pushing the boys away. Doctors have the same problem and I found among the older doctors that the negative attitude toward abortion was really quite difficult to overcome. They have been told for years that to do an abortion is illegal, and then all of a sudden the process is legalized. A high school counselor might note that the girls that report the latest for an abortion are the teenagers and we have had to refer them elsewhere. We do not do saline injections in our office or in our community. Saline injections are done after 14 weeks of pregnancy so we refer them to other areas. Most of our referrals have been 13, 14, and 15 year old girls who are afraid to tell anybody: parent, counselor, anybody else and just keep hoping that they are going to get their period.

The only other time that I have noticed problems with abortion has been with

those girls who have had abortions, gotten married and had difficulty getting pregnant. They have real emotional problems, but these are no greater than with the girl who has had a baby, given it up for adoption, then gets married and has trouble getting pregnant. This becomes a sterility problem. There is no difference here. So the alternative here is nill as far as I personally am concerned. This then concludes my effort to share with you some of the things that have occurred in our little county.

THE PERSPECTIVE OF A COUNSELING CENTER DIRECTOR

I would like to share with you a little of my own experience prior to the legalization of abortion in New York State, and then some of the repercussions that I as a counselor have experienced after legalized abortion.

Prior to July of 1970, I, along with many counselors in New York State dealt with unwanted pregnancies primarily in the cognitive domain, with assurance that we could assert that abortions were illegal and, therefore, a woman with an unwanted pregnancy had, for the most part, only one legal alternative. She could have the child and then either keep it or give it up for adoption. Of course, there were a few grave exceptions to the rule as in the case of serious psychiatric or medical problems. For the most part the counselor in the college setting could well identify with those of the helping professions. It was a pretty antiseptic procedure. If they chose to have the child legally, they could be referred, often times with some delay and some effort, and then we as counselors could try to help them return to a rather normal routine or a normalized behavior. However, there were at the same time a number of women who chose to have illegal abortions. These often took place in New York City, Washington, D.C. or Puerto Rico. A few even went to England where abortions were legal at the time. However, the counselor's psy remained pretty well intact, since he had minimal if any contact with these women prior to

the decision. However, several women did appear in my office after rather traumatic experiences with backroom abortionists.

One client, a college sophomore, had an abortion in Washington in a backroom setting and was suffering from a series of nightmares. She lived in rather constant fear of her parents finding out about the abortion. She and the boyfriend had planned this out on their own, and she felt that she had betrayed her parents and could not in anyway confront or discuss this with them. After two years, she was still experiencing a good deal of difficulty with interpersonal relations with males. She still remained quite frigid to the time of graduation. I think this girl would still have to pursue some type of counseling or adjustment in dealing with members of the opposite sex.

A second client suffered rather severe trauma after being partially aborted by a nurse, and needed hospitalization to prevent some rather serious physical damage. It was interesting to note that she too lived with this tremendous fear of her parents finding out. We continued the therapeutic relationship through most of her senior year and managed to reduce the amount of acute anxiety attacks she was periodically experiencing. She was also a girl who needed to continue therapy after her departure from college. These are typical of the encounters we experienced prior to the legalized abortion law but they were not very common.

Shortly after July 1 of 1970, the affective domain in counseling was pretty well thrust upon the counselors of New York State. It allowed abortion on demand up to 24 weeks of pregnancy with no stipulated residency requirement.

Now, I would like to just talk a little bit about the view after this law was passed. The initial impact from the law was not from the clients coming in for counseling, but from some private referral agencies that sprung up overnight. Telephone calls were coming in on a pretty regular basis from these agencies soliciting

our abortion business. This was a little disturbing. The descriptive literature soon followed, and it began to make one wonder if the abortion referral agencies had not hired a travel agency to write their materials. The glowing description of their service promised deluxe accommodation, limousine service from the airplane to the center, entertainment for male friends who would escort clients, and a light lunch for the escort while the client went through the abortion process. A return limousine trip back to the airplane was provided after the procedure had been performed. As you can well imagine, we didn't take them up on their offers.

The other alternatives to abortion didn't keep pace. For those who decided to keep a child, the adoption agencies were not as quick to respond as the abortion agencies were. But now with the new abortion law, and abortion as a legal alternative, more individuals with unwanted pregnancies came to the counselor. The counselor was now involved for the first time, in many cases, with the decision as to what the alternative would be with the unwanted pregnancy, particularly in reference to abortions. The counselor had to become knowledgeable to all alternatives to an unwanted pregnancy.

As a counselor, I felt that the pressure of the abortion referral agencies offered a quick relief to an emotionally charged and scared co-ed. At the same-time, I had to keep in mind that it was a viable option for some clients. The attraction for abortion was increased as the price went down, and students learned that emergency loans through the College Financial Aids Office were available for personal reasons. Fortunately, the State of New York intervened shortly to limit the practice of private profit-making abortion referral agencies. Within the first year of the new law, the agencies were outlawed, and most of our students seeking abortions utilized a local reputable physician, such as Dr. Jacobus or went through Planned Parenthood. With the development of the Birthright Program, other agencies

became more active in offering assistance in carrying a pregnancy to birth. As a counselor, I really haven't felt their impact as much as I guess I would like to, but I think Father O'Heron will cover this area more specifically.

In the counseling encounter, I felt the need to establish a close working relationship with the client which allowed for a thorough explanation of the alternatives; and in particular an option for follow-up counseling after the decision was made.

The added option of a legalized abortion for an unwanted pregnancy has unsettled my psyche at times. In working with clients who often go the abortion route, I question how constructive or destructive my role was in this matter. The counseling encounter for me involves an unconditional positive regard for the client and the valuing of the worth and dignity of the individual. Therefore, counseling with those with unwanted pregnancies froces each of us to do some introspection. I am sure my uneasiness is compounded by being the father of four young daughters. My thoughts were also stirred by the news release from the New York State Health Department indicating that in the first year of the abortion law, 62 live births were recorded in the abortion process. Yet as counselors, we must recognize that the ultimate decision is not ours and to reflect our personal biases may not only destroy the immediate helping relationship, but a later helping relationship that may be needed. It is my contention that counseling services need to provide more effective preventive counseling programs. In the city of Cortland and at the State University College of Cortland, New York, we are in the process of implementing some of these preventive counseling programs. This includes a program on Human Sexuality that ties in with new-student orientation. We have advised our students to buy a booklet, and I am not trying to advertise for it specifically, but it is called, "Sex is Never an Emergency," by Dr. Elaine Pearson (1970). We have made

this available through our college bookstore; and we used this as a foundation for our panel presentation on Human Sexuality that included a gynecologist, clergymen, counselors, students and health workers. The panelists were also open to invitations for informal talks on sexuality in college resident living units. Follow-up programs were provided through Planned Parenthood and the campus Newman organization. Recently, a student publication on sexuality was distributed and we hope this will be done on a continuing basis; and as Dr. Jacobus mentioned, we have recently opened up a clinic for family planning with the help of a state grant. Now, these projects are only a small indication of the job that needs to be done. My experience now leads me to feel even more strongly that our goal in dealing with unwanted pregnancies is to strive for pregnancy prevention rather than pregnancy termination.

THE PERSPECTIVE OF A BLACK COUNSELOR

All across the country black people are asking many questions such as: "Is birth control just a white man's plot to contain the black population?" "Is it just another scheme to cut back on welfare aid or still another method of keeping the black man down?" Community people on one end are ridiculing the system for disguising a very definite method of exterminating black people through the use of birth control and abortions, while the other segment of the community feels that the use of birth control is a legitimate means of controlling family size. The questions come mainly from black ghetto residents, not middle-class blacks, because they have accepted contraceptive practices well. The inquiries come not only because of concern about containment and welfare cutback, but also because of a very prevalent idea that birth control actually means black genocide. The genocide accusations stem from the black experience with regard to racism and paternalism. In the eyes of many blacks, family planning is being advocated in a soci-

ety steeped in racism, which builds in the possibility that family planning, like other systems, can be used to advance the whites' interests. Blacks know all too well the effects of racism...It implies by its very nature biological, psychological and cultural genocide. Likewise, in the practice of paternalism, the poor and less educated are discharged from participating in public policy or decision-making, so that the white affluent and professionals can become controlling forces over their lives.

Black men particularly happen to be the loudest protesters against birth control. Many of these men view birth control measures as a threat to their virility. They are calling on their women not to take the pill, but to reproduce as many children as they can. These children will aide the revolution in the form of nation building. Other black men contend that for every child that is aborted, a potential leader is killed. Black Muslims, Black Nationalists and other religious groups are staunch supporters of anti-birth control practices. Muslims see no place in the black woman's life for fun and folly when it comes to engaging in sexual encounters. The salvation of their black nation is dependent upon the women to produce offspring, who will be brought up in the Muslim tradition. There are black women with nationalistic outlooks who believe that methods of contraception and abortion are counterproductive to nationalistic aims. However, there are many women with middle-class beliefs who are quite antagonistic to the genocidal accusations and consequently see family planning as being a legitimate means of controlling family size with no strings attached. For this group of women, the use of birth control methods or the possibility of having an abortion allows them the freedom of engaging in sex relations without being penalized. The concern of these women is that they have the freedom to decide whether to have children or not. The question is: "Do black women have the freedom of choice?" If it does in fact exist

for them, perhaps it is very limited. Freedom of choice can only be a reality when the economic and social security of the community becomes a first priority. Before advocating freedom of choice, I think it is necessary to equalize the economic, social, and political circumstances that affect the choices; and this can only be done by equalizing the chances of black people. As the situation now exists, choices made by black women are limited to child-bearing out of ignorance, or limiting child bearing in order that a fewer number of children will be born into a family, not to suffer hunger, poor housing, unequal education, and general racial discrimination. Black people face this kind of freedom of choice. Other black women, usually of the lower class, feel that birth control is the freedom to fight genocide of black women and their children. Many of these mothers feel that having too many babies stops them from supporting their children, telling them the truth about racism, and fighting black men who still want to use and exploit them.

Looking at what has been discussed thus far, it seems as though black men in general are anti-birth control and abortion. However in reviewing a study that was conducted by Castellano and Darity (1971) at the University of Massachusetts on different black views of birth control, it was reported that men falling into different age brackets were recorded as having different reactions to the genocide issue. The results of one portion of the study showed that a significant minority among men 30 and under agreed with the thought that encouraging birth control on blacks was an effort to eliminate them. In another phase of the study, individuals were asked to respond to the statement, "All forms of birth control are designed to eliminate blacks." Fourteen per cent agreed; 84 per cent disagreed. It is significant to point out here that 29 per cent of the males 30 and under agreed with the statement, while 100 per cent of the males 30 and over disagreed with the statement.

In response to the statement, "Encouraging blacks to use birth control is comparable to eliminating this group from society," two per cent agreed and 72 per cent disagreed. Among men 30 and under, 47 per cent agreed. Of men over 30, 27 per cent disagreed. In all three of these cases, those under 30 seemed to be more reactionary in their beliefs concerning black genocide, whereas those 30 and over seemed to generally have a greater disbelief in the idea that birth control programs are an attempt to eliminate blacks from the population.

As was stated earlier by Dr. Fadale, 215,453 induced abortions were performed in New York State during the first year under the new law. Of the 40,476 abortions to non-white patients, both residents and non-residents of New York State, 35,806 were reported in New York City and 4,670 were reported Upstate. These statistics were representative of blacks and Puerto Rican women throughout the state. The following statistics will only be representative of black women who are residents of New York City. Looking at the number of induced abortions performed on non-white women over a nine month period, black women accounted for 42 per cent of the total number of abortions and only 31.6 per cent of the live births, as compared to white women who accounted for 48 per cent of the abortions and 51 per cent of the live births. The ratio of abortions to live births for black women residents were about six abortions for every ten live births, where as for white women the ratio was four abortions for every ten live births. The statistics show that the ratio of abortions to live births was considerably higher for black women than for white women. New York's experience indicated that when abortions were made available and accessible at a low cost, it would be used to terminate pregnancy by blacks as well as whites. There is no doubt that the black women in particular have benefited from the new law.

It is my belief that birth control can become a progressive measure for black

people if safeguards are built in to counteract racism. In my opinion, this safeguard is black control of Family Planning Programs in black communities. This would soften the white plot idea, which leaves so many uninformed people caught between the pressures from militant groups and their own questions for fewer children. There is a need for greater participation of black people in the professions, and this can be done by increasing the educational opportunities for black people in medical, social, welfare and governmental fields. As a practical means for survival, black people should refuse to support any kind of white dominated venture where blacks are the recipients, yet hold no power or control over the program. All indications point up that relations with the black community in regard to birth control are going to continue to be laden with conflict, as long as blacks are excluded from decision-making on policy and program development. Regardless of white motives whether they be benevolent or racist, blacks are going to have criticism of white dominated policies and programs in black communities. In conclusion, I would suggest that black people not be confronted about Family Planning Programs unless whites are willing to talk about training them to staff and run these programs.

THE PERSPECTIVE OF A CATHOLIC PRIEST

My fellow panelists are a difficult group to follow. Let me begin with the observation that my own personal concern and interest regarding the subject of abortion is more than purely theoretical. My own personal experience as a college chaplain has involved, and does involve, counseling situations related to abortion almost always after-the-fact with those who experience problems and difficulties living with abortion. I recognize that an objection can be raised that my experience is limited and one-sided: restricted only to women who, after-the-fact, experience difficulty and who choose to consult with a college chaplain about it. However, this is one side of the abortion issue, a side that I feel may be too easily overlooked. While

I recognize from the outset that my experience is limited, just let me say that looking into the eyes of girls who experience problems and difficulties living with abortion after the fact, keeps me from approaching this issue in purely academic terms.

The term birthright itself is both a specific and a generic term. In a general way, it refers to all alternative-to-abortion programs whether these happen to be purely informational or also involve services and referrals. In a very specific way, Birthright refers to those alternative-to-abortion programs which are officially incorporated under that name and are affiliated with the original founding organization in Toronto, Canada. Here I will be speaking of birthright in the more general way, referring to all alternative-to-abortion programs with an emphasis upon a woman's right to give birth to her child and upon a moral right of the unborn child to be born.

Before sharing some of the statistics of birthright organizations in New York State with you, I would like to begin with a few distinctions. I mention these distinctions not in order to minimize in any way the very deep differences that exist on this topic, but rather in the hope that they may help to make conversation and dialogue possible, clarifying some of the issues. A very obvious distinction is the distinction between <u>morality</u> and <u>legality</u>. Morality means commandments, moral principles, moral imperatives (whatever terminology you prefer) in relation to the conscience of persons. Legality means the ways in which the common good of the pluralistic society will best be promoted or least hindered by means of law. While the distinction is obvious enough, the differences in viewpoint regarding the relationship of the moral and the legal are among the most hotly debated differences related to abortion.

A second distinction may be made regarding human activity. There is a great

difference between declaring, on the one hand, what is morally right or morally wrong and, on the other hand, declaring who is morally right or morally wrong. When we are speaking about what is morally right or wrong, we are speaking in the realm of religious moral teaching. At this level the church or religious faith groups do have both a right and a responsibility to say something about the moral aspect of human activity. On the other hand, when we speak of who is morally right or morally wrong in the sense of who has sinned and to what extent, or the other side of the coin, who has not sinned and to what extent, then we are in the realm of the conscience of the individual person, or in theological terms, how he stands here and now before God. At that level the church should not, cannot, and in fact does not, claim to make moral judgments on persons. In fact, it is a matter of church belief that an individual person cannot make an absolutely certain judgment even regarding himself and how he stands here and now in the sight of God. Therefore, the church is in no position to claim to make such judgments. However, this non-judgmental aspect does not in anyway take away the religious faith groups' responsibility of saying something about the moral aspect of human activity. Nor does a non-judgmental attitude imply in any way a watering down or diluting of the Judaeo-Christian notion and understanding of sin, as deeply present in the human condition both in persons and in society.

A further distinction would be in moral terms, that of preventive means of birth control and abortion as moral issues. If I might, just for a moment, restrict myself to the household of the Catholic Church, the consensus within the Catholic Church of opposition to abortion on moral grounds stands in contrast to the issue of preventive means of birth control. In the summer of 1968 following Pope Paul's encyclical on birth control, in this country a statement of responsible dissent was issued by several hundred Catholic teachers and theologians regarding some aspects of the encyclical, notably that touching upon preventive means of birth control. By way of con-

trast, not only within the official church teaching as expressed in the Vatican Council but even among theologians, liberal and conservative alike, a consensus of opposition on a moral basis continues related to abortion. The reason for the lack of consensus in one case and not in the other would seem to be fairly obvious. Birth control by preventive means and abortion are very different moral issues. In the first case, there is the prevention of conception; in the second there is the destruction of life already begun. Simply expressed, the difference is the fetus and this makes the issues different indeed. Among many religious faith groups there seems to be a growing awareness of preventive means of birth control and abortion as distinct moral issues. For example, within the last couple of years some Protestant denominational groups have made statements related to abortion as a moral and/or legal issue all of which at the very least seems to indicate both an awareness and a willingness to see these as separate issues.

To turn to some of the Birthright statistics, the statistics themselves are quite uneven from the cities of New York State for a number of reasons. First, the varying lengths of time that the programs themselves have been under way, and the degree of development attained, and secondly, the basic structure of the program of abortion alterntives varies greatly from one city to another. Thus, for example, in New York City and in Buffalo, the Birthright Programs are directly affiliated with Catholic Social Services, and thus become a service offered to the community by Catholic Social Services. In other cities, such as Utica, Ithaca, and Oswego, birthright is a non-denominational, independent, incorporated entity. In both kinds of situations, the Birthright Programs work in unison with the already-existing social agencies in such matters as pregnancy tests, V.D. tests, and adoption procedures.

The New York City Office of Birthright reports over four thousand calls received in a matter of months which have led to over seven thousand personal appointments

made to pursue further the alternatives to abortion. Buffalo Birthright reports over 1,200 calls of which over two hundred have resulted in personal appointments to pursue further the alternatives. Buffalo's Birthright now averages between two or three calls a day. Syracuse's Birthright averages approximately two calls a day. One great variable I noticed in compiling information is the publicity that is to be found in different cities regarding the very existence of the programs. The response tends to be proportionate to the extent of how well the existence of birthright has been publicized. In Syracuse for example, a month following the publicizing of the existence of the program, the number of calls received more than doubled during that time. The Birthright Programs do offer an alternative and do also offer an alternative for those who oppose abortion on moral grounds to do something constructive about it. It does very little good to deplore the presence of abortion and fail to do anything in the way of providing meaningful alternatives.

I have the feeling that in the midst of all the intense debate that continues to go on, that one beneficial side effect has been the focusing of our attention upon human life at all stages and in all forms from conception until death. Respect for human life involves facing the implications of abortion as a moral and legal issue, but at the same time, it also involves facing the implications of our country's involvement in South East Asia---very different issues and yet similar from the point of view that each in some way touches on human life. All life is interrelated, and as each of us strives to develop a personal philosophy of respect for human life, we recognize we cannot pick and choose our issues.

In conclusion, something of this was touched upon by Shriver (1968) and was expressed in the following words:

> "If we reject the Hard Society
> and choose instead
> the way of love,
> we can move swiftly toward creating a
> country where material pursuits are not

the end of our lives, where no child is
hungry or neglected;
and where even defective
children are valued because they call forth
our power to love and serve without
reward.
Instead of becoming the Hard Society,
we could become the just and
compassionate one.
Instead of destroying life,
we could destroy the conditions
that make life intolerable.
In this society, every child,
regardless of his capacities or the
circumstances of his birth,
would be welcomed, loved and cared for--
and abortion would cease to preoccupy us
because it would not be necessary."

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